Revised 04/05

MaineCare

Federally Qualified Health Centers

Billing Instructions

Claim Form CMS-1500 (12/90)

Mail Claim(s) to:	MaineCare Claims Processing M-500 Augusta, Maine 04333
Mail Adjustment(s) to:	MaineCare Adjustments M-1000 Augusta, Maine 04333

Department of Health and Human Services
Bureau of Medical Services

PICA PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
ƒ (MEDICARE #) ƒ (Medicaid #) ƒ (SPONSOR'S SSN) ƒ (VA File #) ƒ (SSN OR ID) ƒ (SSN) ƒ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, first Name, Middle Initial)

. PATIENT'S BIRTH DATE SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENTS ADDRESS

6. PATIENTS RELATIONSHIP TO INSURED
SELF ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

PATIENTS STATUS
SINGLE ☐ MARRIED ☐ OTHER ☐
EMPLOYED FULL-TIME PART-TIME
☐ STUDENT ☐ STUDENT ☐

CITY STATE

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( ) STATE

9. OTHER INSURED'S NAME (L Name, F Name, M Initial)

10. IS PATIENTS CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

33. EMPLOYMENT? (CURRENT OR PREVIOUS)
☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH SEX
M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH SEX
MM DD YY
M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State)
☐ YES ☐ NO _____.

b. EMPLOYER'S NAME OR SCHOOL NAME

c EMPLOYERS NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
☐ YES ☒ NO ***if yes,*** return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.

SIGNED _____. DATE _____.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____.

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MM DD YY FROM TO MM DD YY

19. RESERVED FOR LICAL USE

20. OUTSIDE LAB? $CHARGES
ƒ YES ƒ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.(RELATE ITEMS 1,2,3 OR 4, TO ITEM 24E BY LINE)
1. 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE From MM DD YY	to MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAY OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25 FEDERAL TAX I.D. NUMBER SSN EIN
☐ ☒

26. PATIENT'S ACCOUNT NUMBER
your in house acct #

27. ACCEPT ASSIGNMENT?
ƒ YES ƒ NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
,
address, etc.

PIN GRP#

PATIENT AND INSURED INFORMATION

YSICIAN OR SUPPLIER INFORMATION

INFORMATION PROVIDERS NEED TO KNOW:

1. MaineCare processes CMS-1500 claim forms for services covered by the following programs:

    - Bureau of Medical Services
        - MaineCare
    - Department of Health and Human Services
    - Bureau of Health
        - Maine Breast and Cervical Health Program (MBCHP)
        - Children with Special Health Care Needs
    - Bureau of Child and Family Services

Many of the above programs require Prior Authorization.

2. Providers must:

    - Use the current ICD diagnostic code book and specified procedure codes in the current Chapter III of Section 31, FQHC Services, of the MaineCare Benefits Manual.

    - Use CMS-1500 claim forms without bar codes.

        - If you purchase claim forms with bar codes, you must cover the bar code before submitting your claim to MaineCare or the claim may be returned to you. MaineCare uses the bar code area to stamp its unique transaction control number (TCN).

    - Submit claim on an original CMS-1500 claim form. Faxed, photocopied and laser-printed claim forms will not be accepted.

      MaineCare will continue to accept any handwritten claims. However, MaineCare may discontinue this policy at any time without notice.

    - MaineCare managed care services require a referral from the Primary Care Provider.

    - You may also bill electronically through EMC batch billing.

Instructions for Completing CMS 1500 for MaineCare Covered Services

Only the required fields are addressed. All others are not required for MaineCare billing. All information must be contained within the designated field. **Do not overlap information into other fields/boxes.**

Box #:

1a. Enter the member's MaineCare ID number exactly as shown on the MaineCare ID Card. Do not use dashes or hyphens. Providers must verify eligibility for claims submitted. You may verify a member's eligibility status by using the medical eligibility swipe card system, interactive voice response system (1-800-452-4694 or 207-287-3081), or the MeCMS website (http://www.maine.gov/bms/MECMSHomePage.htm). Eligibility must also be verified for claims submitted for batch processing.

2. Enter the member's last name, first name and middle initial (if any) from the MaineCare ID Card.

3. Enter the member's date of birth (DOB), using 8-digit format. **Example:** June 25,1925 would appear as 06251925.

   Check M or F as appropriate.

5. Enter member's address, including zip code.

9. If the member is covered by a primary insurance other than MaineCare or Medicare, enter the name of the policyholder.

9a. Enter the policy or group number of the primary insurance other than MaineCare or Medicare.

9b. Enter the primary insurance's policyholder's DOB and sex.

9d. Enter the name of the primary insurance plan or program name. **Example:** Anthem Blue Cross. **Do not** enter Medicare or MaineCare in this block.

10a-c. Check the appropriate blocks.

11d. If the MaineCare member is covered by other primary insurance, check Yes. If Yes, providers must complete fields 9 a-d

17a. If the member is enrolled in MaineCare Managed Care, and the service requires a referral, enter the primary care provider's (PCP's) location-specific 9-digit referral number.

19. If you are billing a J code for an injection of a drug you supplied, enter the NDC code for that drug. **Only one J code may be billed per claim.**

21. Enter the appropriate ICD-9 code only. Use the code with the greatest degree of specificity available. **Do not enter the description of the diagnostic code**.

22. If this is an adjustment claim, enter the appropriate adjustment code: 7 – Replacement of previous claim, 8 – Void or Cancel. **Enter the previous TCN in space provided for "original reference number"** for the applicable line. Please be sure to include copies of original attachments with the corresponding TCN.

23. Enter the prior authorization number issued by the applicable unit or agency for services and supplies billed on this form, if applicable.

24. For each line item billed, you must include one date, place of service, procedure code, and amount charged per line. **No more than six lines may be billed per paper claim.**

A. Enter both "From" and "To" dates of service using 8-digit format. "From – To" dates must be consecutive and continuous. Otherwise, enter only one date per line. **For each line, bill for dates of service provided in one month only. Do not use punctuation.**

B. Enter the appropriate **2 digit** Place of Service code for the service provided from the following list:

03	School
04	Homeless Shelter
12	Home
13	Assisted Living Facility
14	Group Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
32	Nursing Facility
33	Custodial Care Facility
50	Federally Qualified Health Center
99	Other

D. Enter the appropriate procedure code in this block. Procedure codes are listed in Chapter III of Section 31, Federally Qualified Health Center Services, of the MaineCare Benefits Manual.

E. Enter the number that refers to the appropriate diagnosis code used in Box 21. Do not use punctuation. **This is now a required field.**

F. Enter the charge for the service you provided (eg. Usual and customary, allowed amount from EOB – see below for discussion of Medicare billing).

G. Enter the appropriate number of units of the supplies or services provided. **Do not use decimal points or fractions,** round off to the nearest whole number. Enter 1 if only 1 unit had been provided. 1 unit of an FQHC visit is 1, not the units of itemized services provided in that visit.

I. Enter a **Y** if applicable. **Y** will prevent a co-pay from being deducted if you are billing emergency services or other co-pay exempt services. Refer to Chapter I of the MaineCare Benefits Manual for a list of exempt services.

J. Enter a **Y** when billing for Medicare coinsurance or deductible.

K. Enter the servicing provider's ID number in this block. A servicing provider's number always ends in –99.

26. If using patient account numbers, you may enter the number (any combination of alpha-numeric up to 12 digits or letters) in this block. It will appear in the left column on your remittance statement. If you do not use patient account numbers, enter the member's name.

28. Enter total charges. This must equal the total of the individual line item charges in 24F.

29. Enter dollar amount paid by other insurance or amount of member's responsibility (spenddown).

    Do not enter Medicare payment or previous MaineCare payment if you are billing for Medicare coinsurance or deductible. Attach the third party Explanation of Benefits (EOB) for all claims involving a third party; when balance billing MaineCare after you have received payment or denial from the primary health plan.

30. Enter the balance due.

31. Please enter the provider's signature and billing date. Signature may be typed or stamped. Date must be in eight digit format (0731998). The date must be the same or a subsequent date to the last date of service on the claim form. Services must not be billed prior to being performed.

32. Enter name and address of facility where the provider rendered the services, if other than home or health center.

33. Enter the provider's name, address and 9-digit billing provider ID number. Be sure the billing number is entered directly to the right of the PIN.

Billing Medicare Coinsurance and Deductibles to MaineCare

At this time the Medicare crossover system is not available for FQHC providers.

You must complete the claim according to MaineCare requirements.

- Continue to use the HCFA-1500 claim form.
- You are required to use a diagnostic code in field 21.
- Enter the procedure codes you usually bill to MaineCare in Box 24D.
- Enter a **Y** in Box 24J when billing for Medicare coinsurance and deductible.
- Charges (Box 24F) must reflect the sum of the Medicare coinsurance and deductible amount as shown on the Explanation of Medicare Benefits (EOMB).
- **Do not enter the Medicare payment in box 29.**

- **Always** attach a copy of the EOMB.

If the EOMB indicates that a MaineCare covered service is denied by Medicare, you must bill MaineCare directly as though it were a straight MaineCare account but with the EOMB denial attached.

If Medicare's denial is for "not medically necessary", MaineCare requires that you appeal the Medicare denial prior to billing MaineCare. You must attach a copy of the original EOMB and a copy of the appeal response to your subsequent claim to MaineCare.

If Medicare denies a service because it is included in another procedure, MaineCare may not pay for the denied service.